Diabetes Patient Flow Sheet

Patient Name:_____ Age:_____
D.O.B.:_____
Male/Female:_____ Type of Diabetes: Type 1 Type 2 Gestational Age of Diagnosis:_____
Physician:_____ Home Glucose Monitoring? Y N
Treatment Regime: Insulin Insulin & Oral Oral Diet Exercise

Family Hx:_____

Patient Hx:

Y N Cardiovascular	Y N Cerebrovascular	Y N Renal
Y N Hyperlipidemia	Y N Hypertension	Y N Obesity
Y N Eye Complications	Y N Foot Complications	Y N _____
Y N Regular Exercise	Y N Tobacco Use	Y N _____
Y N Alcohol Use	Y N Diet	Y N _____

Each Visit	Date					
	Height____ Weight____					
	Blood Pressure-initial, sitting, standing					
	Plasma Glucose Fasting/2hpp					
Every 3-4 Mos.	HbA1C					
	Foot Examination					
Yearly	Complete Physical					
	Dilated Eye Exam					
	Dental Exam					
	Fasting Lipid Profile*					
	Urinalysis/24 hr.* urine/microalb					
	TSH*					
	EKG*					
	Serum Creatinine					
	Flu Vaccine-Pneumovax					
Ongoing Management	Referral to education class					
	Referral to dietitian					
	Preconception Counseling					
	Referral to _____					

This flow sheet is consistent with ADA Clinical Practice Recommendations 2000
*Recommended frequency may differ for children--see companion reference *Recommended Level of Medical Care for Individuals with Diabetes*

Kentucky Diabetes Control Program (KDCP), Department for Public Health, Diabetes Advisory Committee